

# Appendix 1

## Sample Notice of Appeal Rights Letter

February 23, 2000

### Notice of appeal rights.

Mr. I. M. Recipient  
123 Main St.  
Apt. 321  
Anytown, WI 53700

MAID: 123-45-67890  
County Social/  
Human Service Office: 608-123-4567

Appeal Date: 8 April 2000

Dear Mr. Recipient:

Certain services must be reviewed and approved by the State of Wisconsin Division of Health Care Financing (DHCF) before payment may be made by the Wisconsin Medicaid program. This process is called Prior Authorization (PA).

Your provider requested that the following services be approved:

W9930 Home Health Nursing Initial Visit (3v/wk x 9wks) (27 Visits)  
W9919 Home Health Physical Therapy (3v/wk x 6wks, 2v/wk x 2wks) (22 Visits)

The prior authorization request, PA No. 1234567, was reviewed by appropriate DHCF professional consultants, and services have been denied or modified as follows:

#### Denied Services:

W9919 Home Health Physical Therapy (3v/wk x 6wks, 2v/wk x 2wks) (22 Visits)

#### Modified Services:

W9930 Home Health Nursing Initial Visit (2v/wk x 9wks) (18 Visits)

DHCF's denial or modification of the services requested was made for the following reasons:

**Service(s) do not meet Medical Assistance guidelines.**  
**You can receive the care you need during the visits approved.**

Please contact Anytown Home Health Services for more information. Your provider has a copy of the prior authorization request form and can explain the reasons for the denial/modification.

**The regulation(s) that support DHCF's actions to deny or modify your provider's request are included in Wisconsin Administrative Code, HFS 107.02(3)(e).**

## Appendix 1 (continued)

HFS 107.02(3)(e) In determining whether to approve or disapprove a request for prior authorization, the department shall consider: 1. The medical necessity of the service; 2. The appropriateness of the service; 3. The cost of the service; 4. The frequency of furnishing the service; 5. The quality and timeliness of the service; 6. The extent to which less expensive alternative services are available; 7. The effective and appropriate use of available services; 8. The misutilization practices of providers and recipients; 9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines; 10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality; 11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and 12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

HFS 107.02(3)(e) [General limitations: Prior authorization: Departmental review criteria] in determining whether to approve or disapprove a request for prior authorization, the department shall consider: 1. The medical necessity of the service; 2. The appropriateness of the service; 3. The cost of the service; 4. The frequency of furnishing the service; 5. The quality and timeliness of the service; 6. The extent to which less expensive alternative services are available; 7. The effective and appropriate use of available services; 8. The misutilization practices of providers and recipients; 9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines; 10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality; 11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and 12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

You may appeal the DHCF decision in accordance with state and federal law within 45 days. To file an appeal:

- 1) Call your County Social/Human Services office at the telephone number listed above for an appeal form and/or assistance in completing it, or
- 2) Write to the Division of Hearings and Appeals at the following address by the 45-day Appeal Date indicated in the caption of this letter:

**Division of Hearings and Appeals**  
Department of Administration  
P.O. Box 7875  
Madison, WI 53707-7875

The appeal form or letter should include:

- the name, address, phone number
- the Medicaid number of the person for whom the appeal is being made
- the Prior Authorization number 1234567, and
- the reason you think the denial or modification of the PA is in error

REMEMBER: You must mail or deliver your appeal to your County Social/Human Services Office or the Division of Hearings and Appeals so it is **received by the 45-day deadline or by 8 April 2000.**

## Appendix 1

### (continued)

You will lose your right to an appeal if your appeal is not received by the County Social/Human Services Office or the Division of Hearings and Appeals by 8 April 2000.

If you file an appeal:

- The State Division of Health Care Financing will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you and your designated representative.
- You or a representative that you choose (friend, relative, attorney, provider, etc.) will have an opportunity to explain your need for the service to a hearing officer. (You may want to ask your county agency if there is free legal help available in your area.)
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal. Hearings are held at your County Social/Human Services Office. DHCF staff may also appear in person or by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision in writing and advise you of any additional appeal rights.

Whether or not you appeal the decision, the Medicaid program will pay for any services it has approved. After the hearing officer makes a decision, Medicaid will continue to pay for the approved services plus any additional services the hearing officer directs Medicaid to pay.

If you need information about accommodation for a disability or for English language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (TDD) immediately so arrangements may be made. These telephone numbers are at the Division of Hearings & Appeals and are to be used only for the purposes indicated. Staff at those numbers will not be able to provide you with information about your specific case.

Sincerely,

Sincerely,

Administrator  
Division of Health Care Financing

Chief Medical Officer  
Division of Health Care Financing